NWA Health Solutions
Point.East Acupuncture and Chinese Herbal Medicine
Margaret Marsh, MSTOM, LAc

Name: _____ Date: _____

Address: _____ Phone number: _____ Email _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you had acupuncture therapy before? Y / N How did you learn about the clinic? Dr. Referal Friend/ Family Yelp Internet Other

Please let us know if someone referred you. We would like to thank them! Referred by: _____

HEALTH HISTORY

Please indicate your top 3 concerns for which you are seeking treatment.

1. _____

Please rate your overall discomfort between 1(very minimal) to 10 (extremely severe):
1 2 3 4 5 6 7 8 9 10

2. _____

Please rate your overall discomfort between 1(very minimal) to 10 (extremely severe):
1 2 3 4 5 6 7 8 9 10

3. _____

Please rate your overall discomfort between 1(very minimal) to 10 (extremely severe):
1 2 3 4 5 6 7 8 9 10

Are your current concerns related to a motor vehicle accident? If so, what was the date of the accident?

Please briefly describe the accident _____

_____

Did airbags deploy? Were you wearing a seatbelt? Were emergency services rendered after the accident?

Have any xrays or MRI's been taken since the accident?

Any additional health conditions we should be aware of? _____

_____

Please list any prescriptions, supplements, vitamins, or herbal therapy you are presently taking along with dosage:

_____

Please note any surgeries or major hospitalizations or significant traumas (physical or emotional): _____

_____

Do you have any scarring on your body? _____ Any artificial body parts? _____

Please indicate if any of the following pertain to you: HIV Hepatitis Seizures Pacemaker Blood-Thinning Medication Bleeding disorders Pregnancy

Are you aware of any condition you may have for which you could be sensitive to mild electrical stimulation? Y N

General Symptoms (please circle all that apply): allergies _____

Chills Fever Body Aches Appetite Change Sudden Weight Loss or Gain Disturbed Sleep Cold Hands and Feet Varicose Veins Night Sweats Joint Pain/Stiffness Frequently Cold or Hot Excessive Thirst Bruise/Bleed Easily Sweat Easily Low Energy Low Libido High Libido Irritability Shortness of Breath Soft/Brittle Nails Easily Catch Colds Light-Headed/Dizziness Body and/or Head Feels Heavy Tired after meals Allergies Stress Depression Anxiety Difficulty Falling or Staying Asleep Sleep Apnea Other _____

Approximate number of hours per night that you sleep _____

Do you have a bowel movement every day? (please circle one) Y N

MAJOR SYSTEMS (please circle all that apply)

Skin and Hair: Dryness Rashes Itching Redness or Sensitivity Dandruff Hair Loss Other _____

Head, Eyes, Ears, Nose, Throat: Headaches Migraines History of Concussion Blurred Vision Red, Itchy and/or Dry Eyes Ringing in Ears Difficulty Hearing Ear Aches Lip or Tongue Sores Bleeding Gums Nosebleeds Nasal Drainage Loss of Smell or Taste Facial Pain Jaw Clicking Toothaches Other _____

Cardiovascular: Low/High Blood Pressure Irregular Heartbeat Palpitations Shortness of Breath Fainting Chest Pain Cold/Numbness/Tingling/Swelling of Hands or Feet Stroke Lung Congestion Other _____

Respiratory: Frequent Cough Cough Blood Asthma and/or Wheezing Difficulty Breathing Other _____

Gastrointestinal: Nausea/Vomiting Diarrhea Constipation Gas/Bloating Belching Abdominal Pain Indigestion Bad Breath Blood or Mucous in Stool Hemorrhoids Laxative Use Other _____

Urogenital: Pain with or Blood in Urine Change in Flow Kidney Stones Cloudy Urine Other _____

Musculo-Skeletal: Upper Middle Low Back Pain Neck Pain Joint Pain Other _____

Neurological: Seizures Tremors Loss of Balance/Memory/Concentration Numbness/Tingling Other _____

FOR WOMEN

Date of last period: _____ Number of days bleeding: _____ Number of days in cycle: _____

Flow is: Heavy / Moderate / Light / Clotted Color is: Bright fresh red / Pale red / Brown / Black / Purple

Number of pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Are you currently sexually active? □ Yes □ No Any form of birth control? _____

Are you trying to conceive? □ Yes □ No Fertility problems? □ Yes □ No Decreased Libido? □ Yes □ No

Use of assisted reproductive technologies? □ Yes □ No Any sexually transmitted infections? □ Yes □ No

Post-Menopausal: Age menses ceased _____ Hysterectomy? Age and reason _____

Please circle if you experience any of these other gynecological symptoms: Vaginal dryness Profuse vaginal discharge Yeast infections Tendency for urinary tract infections **Please indicate if you have been diagnosed with any of the following:** Fibroids Fibrocystic breasts Endometriosis Ovarian Cysts Polycystic Ovary Syndrome Pelvic Inflammatory Disorder Other _____

MENSTRUAL HEALTH: BEFORE, DURING, or AFTER PERIOD: Breast Tenderness Bowel fluctuations Moodiness/Weepy Low back Pain Cramps Appetite fluctuations Irritability Headache/Migraine Nausea Fatigue Hemorrhoids Insomnia Bloating Down-bearing sensation Spotting, what color?

FOR MEN

Date of your last prostate exam: _____ Any abnormalities? _____

Please indicate if you experience any of these symptoms: Fertility problems Erectile Dysfunction Frequent Seminal Emissions Painful/swollen testicles Discharge Prostatitis Decreased/Increased Libido sexually transmitted infections

_____ _____

Signature of Patient or Responsible Party Date

Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.
www.nwahealthsolutions.com
info@nwahealthsolutions.com

nwa HEALTHSOLUTIONS
"Beyond Traditional Medicine"

5300 S. Southern Hills Ct., Ste 200
Rogers, AR 72758
P 479.636.1324
F 479.631.0014

Consent to Treat

The information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of NWA Health Solutions to administer such procedures, labs and treatment as they deem necessary. I have read and understand the Informed Patient document. I also understand any nutritional counseling I may receive in this clinic is strictly a recommendation of the doctor. I am aware that the doctors here at NWA Health Solutions are chiropractors, and their nutritional recommendations are based on the education they received through Parker College of Chiropractic. The doctor has answered any questions I may have. The doctor has implied no guarantee of cure.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Consent to Treat Minor

The information I have given this office pertaining to _____ is truthful and complete to the best of my knowledge. I authorize the doctors and staff of NWA Health Solutions to administer such procedures, labs and treatment as they deem necessary to my child/ward in my legal custody. I also understand any nutritional counseling my child/ward in my legal custody may receive in this clinic is strictly a recommendation of the doctor. I am aware that the doctors here at NWA Health Solutions are chiropractors, and their nutritional recommendations are based on the education they received through Parker College of Chiropractic. I have read and understand the Informed Patient document. The doctor has answered any questions I may have. The doctor has implied no guarantee of cure.

Parent or Guardian Signature: _____ Date: _____

Relationship to Minor: _____

Doctor Signature: _____ Date: _____

Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.
www.nwahealthsolutions.com
info@nwahealthsolutions.com

nwa HEALTHSOLUTIONS
"Beyond Traditional Medicine"

5300 S. Southern Hills Ct., Ste 200
Rogers, AR 72758
P 479.636.1324
F 479.631.0014

Informed Patient

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions of the patient. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When VSCs are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body, and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no Doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT TO CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a Chiropractic adjustment if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or learn from healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention to the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions that do not respond to Chiropractic care, may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the Doctor **BEFORE** signing the Consent to Treat.

Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.
www.nwahealthsolutions.com
info@nwahealthsolutions.com

nwa HEALTHSOLUTIONS
"Beyond Traditional Medicine"

5300 S. Southern Hills Ct., Ste 200
Rogers, AR 72758
P 479.636.1324
F 479.631.0014

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____
Patient

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

☐ **Individual refused to sign**

☐ **Communications barriers prohibited obtaining the Acknowledgment**

☐ **An emergency situation prevented us from obtaining Acknowledgment**

☐ **Other (Please Specify)** _____

_____

_____
Staff signature **Date**

Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.
www.nwahealthsolutions.com
info@nwahealthsolutions.com

nwa HEALTHSOLUTIONS
"Beyond Traditional Medicine"

5300 S. Southern Hills Ct., Ste 200
Rogers, AR 72758
P 479.636.1324
F 479.631.0014

We appreciate all of our patients and want to give each one of you the one-on-one time that is needed for your appointment. When you schedule an appointment with our providers, we take that time to devote to you so we can give you the best treatment possible. When you are late, miss your appointment, or cancel an appointment without 24 hour notice, you are taking a time slot away for another patient.

We enjoy all of our patients and want to continue to grow and work with each one of you. With that being said:

NWA Health Solutions will apply a $25 fee for:

- Missed appointments
- Cancelled appointments that are not cancelled without 24 hour notice
- Late arrivals- if you arrive 15 minutes after your appointment time.

Thank you,

NWA Health Solutions

Patient Signature _____

Date: _____

Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.
www.nwahealthsolutions.com
info@nwahealthsolutions.com

nwa HEALTHSOLUTIONS
"Beyond Traditional Medicine"

5300 S. Southern Hills Ct., Ste 200
Rogers, AR 72758
P 479.636.1324
F 479.631.0014

Patient Billing Acknowledgement Form Maintenance/Elective Care/Non-covered**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

If you have United Health Care, UMR or Golden Rule your insurance will only cover up to $50.00 of your care- any charges after the $50.00 is **not** able to be billed to your insurance and will be considered for our cash prices.

If you have Medicare or Medicaid Dr. Josh and Dr. Sarah Rowden have opt out as being in network providers. Please be aware that we have to have a signed consent from the patient before Dr. Josh or Dr. Sarah treat any Medicare and Medicaid patient's. This consent form acknowledges that you have been informed of NWA Health Solutions option to opt out of being a Medicare/ Medicaid provider and you have the understanding that we will not be billing your insurance for services rendered in our office.

PROVIDER

Services to be provided are listed below:

- Chiropractic Manipulative Therapy: 98940; 98942; 98941 (spinal manipulation) 98943 (Extra Spinal manipulation ex: knee, arm, shoulder etc.)
- Modalities/Procedures: 97012 (Roller Table), 97014 (electrical Stimulation), 97140 (Manual therapy) 97110 (therapeutic exercise), Spinal Decompression, and Cold Laser
- DME: Posture Pump, TENS Unit, Lumbar support, lumbar support belt, knee strap, my pillow or Tri pillows
- Other: Xrays

PATIENT

I _____, acknowledge that I have been told in advance that the services/
Patient Name – Printed or Typed provider

Products listed above may or are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature _____ Date _____